United States Department of Labor
Employees' Compensation Appeals Board

R.T., Appellant	)	
and	)	**Docket No. 17-1230**
	)	**Issued: May 3, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Brooklyn, NY, Employer	)	

Appearances:
Thomas S. Harkins, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 15, 2017 appellant, through counsel, filed a timely appeal from an April 6, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish cervical spondylosis with myelopathy causally related to the accepted November 16, 2015 employment injury.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On November 19, 2015 appellant, then a 61-year-old letter carrier, filed a traumatic injury claim (Form CA-1), alleging that, on November 16, 2015, he was carrying two bundles of mail, tripped on a step, and fell, injuring his forehead and head. He claimed a closed head injury and a traumatic hematoma of the forehead. Appellant stopped work on November 16, 2015. The initial medical record provided was a November 16, 2015 physician assistant's note indicating that appellant would be off work until his condition improved.

By letter dated December 3, 2015, OWCP advised appellant that his claim was originally received as a simple, uncontroverted case which resulted in minimal or no time lost from work. The claim was administratively handled to allow payment for limited medical expenses, but the merits of the claim had not been formally adjudicated. OWCP advised that, because he had not returned to full-time work, his claim would be formally adjudicated. It requested that appellant submit additional factual and medical information including a comprehensive medical report from his physician regarding how specific work incidents contributed to his claimed injury.

Appellant provided a December 3, 2015 report from Dr. Stephen A. Kulick, a Board-certified neurologist, who first saw appellant in 2011 for neck pain and hand numbness which he was noted to have had for years. A cervical spine magnetic resonance imaging (MRI) scan revealed cervical spondylitic spurring and spinal cord compression with myelomalacia. Dr. Kulick indicated that a neurosurgeon had recommended a cervical fusion and anterior discectomy, but appellant did not have the surgery. He indicated that appellant had several falls in 2013 and 2015. Appellant related that, while working as a letter carrier on November 16, 2015, he struck his right frontal region and sustained a right periorbital hematoma and a right scalp hematoma. He reported headaches, dizziness, some depression, insomnia, and loss of appetite. Dr. Kulick noted findings of a healing right supraorbital hematoma, right infraorbital periorbital hematoma, ecchymosis, an old scar over the left frontal region, normal motor examination in the arms and legs, brisk reflexes, positive Hoffmann's bilaterally, hyperactive knee jerks, and defective vibratory perception in both legs below the knees. He diagnosed cervical spinal cord compression secondary to cervical spondylitic disease. Dr. Kulick recommended further testing and evaluation. He advised that appellant should not work as a letter carrier.

On December 30, 2015 appellant was treated by Dr. Philip W. Kramer, a Board-certified ophthalmologist, for a right eye injury. He reported that while delivering mail he tripped and fell hitting a step and sustaining head trauma, hematoma, and a right eye injury. Dr. Kramer diagnosed ptosis of the right eye.

In a January 5, 2016 attending physician's report (Form CA-20), Dr. Kulick noted a history of progressively worsening falls. On November 16, 2015 while working as a letter carrier, appellant fell striking his head. Dr. Kulick diagnosed cervical spondylosis with myelopathy and intracranial injury. He checked a box marked "yes" indicating that appellant's condition was caused or aggravated by his work. Dr. Kulick noted that appellant was totally disabled for work commencing November 16, 2015. A January 2, 2016 MRI scan of his brain revealed ventricular, sulcal, and cisternal dilatation of a mild-to-moderate degree at the upper limits of normal, no intracranial hemorrhage or susceptibility signal intracranially, and a susceptibility signal within the scalp overlying the left frontal bone of uncertain etiology.

By decision dated January 15, 2016, OWCP accepted appellant's claim for laceration above the right eye and forehead hematoma.[3] By separate January 15, 2016 decision, it denied appellant's claim for cervical spondylosis with myelopathy.

Appellant continued to submit evidence in support of his traumatic injury claim. On November 16, 2015 he was seen in an emergency room by Dr. Aleksandr Ilyayev, Board-certified in emergency medicine, for a head injury. Appellant reported that he tripped and fell at work and hit his forehead on concrete. Dr. Ilyayev noted findings of superficial abrasion, hematoma to the right periorbital area with no focal neurological deficits. A November 16, 2015 computerized tomography (CT) scan of the head revealed a large scalp hematoma overlying the right forehead, no fracture, intracranial hemorrhage, or acute infarction, and age-related parenchymal volume loss. Dr. Ilyayev diagnosed closed head injury without concussion and discharged appellant.

A December 19, 2015 cervical spine MRI scan revealed a diffuse annular bulge slightly flattening the thecal sac at C2-3, diffuse osteophyte ridge associated with the degenerative retrolisthesis of C3 on C4 that compressed the thecal sac and spinal cord, possible myelomalacia, an osteophyte ridge compressing the spinal cord in the midline to a severe degree at C4-5, and a diffuse osteophyte ridge transversed the interspinous space encroaching the intervertebral foramina bilaterally at C5-6. All findings were unchanged from a prior study.

Appellant submitted a January 6, 2016 report from Dr. Kulick who treated him for symptoms related to cervical spinal cord compression secondary to cervical spondylitic disease and several traumatic brain injuries from falling. Dr. Kulick summarized the diagnostic testing. He noted findings on examination of deep tendon reflexes were brisk in the arms, positive Hoffmann's bilaterally in the legs, hyperactive knee jerks, and defective vibratory perception in the legs. Dr. Kulick diagnosed cervical spinal cord compression secondary to cervical spondylitic disease and several traumatic brain injuries precipitated by multiple falls. He recommended that appellant follow-up with neurosurgery.[4]

Appellant was treated by Dr. John Shiau, a Board-certified neurosurgeon, on January 11, 2016 for headaches, dizziness, unsteady gait, memory loss, weakness, and radiating pain from the cervical spine to the left arm. Dr. Shiau reported two major falls resulting in genetic brain injuries and experiencing progressive decline in gait and arm strength. He noted findings on examination of an unsteady gait, positive Hoffmann's sign bilaterally, generalized weakness in the upper extremities, and positive Tinel's sign on the right. Dr. Shiau diagnosed spinal stenosis of the cervical region, disease of the spinal cord, unspecified and unsteadiness on the feet. He recommended posterior cervical decompression surgery at C3-4, C4-5, and C5-6.

In January 16 to December 12, 2016 reports, Dr. Reuven Weiss, a clinical psychologist, saw appellant for memory problems after 2013 and 2015 head traumas. On November 16, 2015 while working, appellant fell and struck his right frontal region sustaining a right periorbital hematoma and a right scalp hematoma. Dr. Weiss diagnosed unspecified mental disorder due to

[3] Appellant received continuation of pay from November 17 to December 31, 2015.

[4] A January 5, 2016 electromyogram (EMG) revealed evidence of neuropathic dysfunction in the left C5-7 and right C5-6 nerve root distributions and bilateral carpal tunnel syndrome. An electroencephalography (EEG) report dated January 5, 2016 revealed an abnormal awake and drowsy EEG because of mild diffuse background slowing, indicative of mild diffuse cerebral dysfunction of nonspecific etiology.

physiological condition, and intracranial injury with loss of consciousness of unspecified duration. Neurocognitive evaluation revealed cognitive impairments related to memory and processing speed. Findings included a notable decline in overall intellectual functioning, auditory and visual attention span deficits, and a high level of mood symptoms.

In a report dated February 10, 2016, Dr. Kulick treated appellant for continuing dementia which developed since his head injuries, traumatic brain injury, and cerebral concussion secondary to falling related to his cervical myelopathy. He noted that appellant was undergoing testing by a neuropsychologist to see the nature and extent of the dementia.

In an undated statement, appellant's spouse indicated that due to appellant's cervical spine injury he was unable to work as a letter carrier after 36 years of service. She noted that appellant had two traumatic head injuries in two years that caused his inability to function normally. Appellant also submitted physical therapy reports.

On January 5, 2017 appellant, through counsel, requested reconsideration and submitted reports from Drs. Kulick and Shiau. Counsel asserted that the medical reports contained a complete description of the work incident and a detailed description of findings along with positive results of objective diagnostic testing. He further asserted that the reports contain unequivocal opinions with rationale supporting that the conditions described were causally related to the work incident and requested that the claim be expanded to include all medical conditions.

In a September 8, 2016 report, Dr. Kulick noted treating appellant on February 28, 2011 for neck pain, numbness in his arms and hands, and weakness. X-rays showed severe cervical spondylitic changes at multiple levels with neuroforaminal encroachment at multiple levels. Dr. Kulick diagnosed cervical radiculopathy secondary to cervical spondylitic spurring and disc protrusion. He noted that appellant was seen by Dr. Shiau on March 21, 2011 for neurosurgical consultation who recommended a C4 corpectomy and anterior cervical discectomy and fusion at C3-4, C4-5, and C5-6. Dr. Kulick noted that appellant was treated on December 3, 2015 and reported that he had had several falls in 2013 and 2015. Appellant reported falling on November 16, 2015, and striking his right frontal region and sustained a right periorbital hematoma and a right scalp hematoma. Dr. Kulick diagnosed cervical spinal cord compression secondary to cervical spondylitic disease and several traumatic brain injuries due to falling. He noted that appellant underwent a C4-5 and C5-6 decompressive laminectomy on February 24, 2016 performed by Dr. Shiau and did well postoperatively. Appellant underwent neuropsychological testing which showed extensive cognitive weaknesses. Dr. Kulick indicated that appellant's falling, weakness in his extremities, and instability were related to moderate-to-severe cervical spinal cord compression secondary to cervical spondylosis. He opined that each of the falls produced traumatic brain injury in 2013 and 2015 which accentuated the neuropsychological abnormalities. Dr. Kulick advised that, based on his examination and the abnormalities noted on the EMG, EEG, the neuropsychological testing and the MRI scans, appellant was totally disabled and incapacitated from any work.

Appellant submitted a September 29, 2016 report from Dr. Shiau who saw appellant for memory loss, difficulty with concentration, and unsteady gait. Dr. Shiau noted a history of treatment beginning on March 21, 2011 for left arm weakness, left leg give away, and chronic neck pain. He noted diffuse degenerative changes and spondylotic disease at C3-6, spinal stenosis, spondylolisthesis, and myelomalacia. Appellant declined surgery. He presented on January 11,

2016 and reported having several falls in 2013 and 2015. Appellant noted findings of myeloradiculopathy, generalized weakness in the arms, unsteady gait, inability to heel-to-toe walk without falling, hyperreflexivity, and positive Hoffmann's signs bilaterally. Dr. Shiau diagnosed spinal stenosis, cervical region, and unspecified disease of the spinal cord. On February 2, 2016 he performed a posterior C3-6 decompressive laminectomies with posterior fixation and fusion. On May 2, 2016 appellant has improved gait, minimal back pain, and no radiculopathy. Dr. Shiau opined that appellant had a baseline cervical spondylosis that resulted in progressive myeloradiculopathy and gait imbalance. He further opined that appellant's most recent work-related fall in November 16, 2015 resulted in post-traumatic brain injury and accelerated his myelopathic dysfunction. Dr. Shiau noted that appellant was completely disabled from work because of residual myelopathy and post-traumatic brain injury.

On January 11, 2017 counsel submitted a supplement to the reconsideration request and provided a report from Dr. Rosemarie Basile, a clinical neuropsychologist. In a December 12, 2016 report, Dr. Basile noted that appellant had two traumatic brain injuries in the past three years, in 2013 and November 2015. Appellant reported that his second traumatic head injury occurred in November 2015 when he was delivering mail. He indicated that he was climbing steps when his foot hit a step and he fell striking his head on the step. Since that time appellant exhibited symptoms of global decline. Dr. Basile advised that individuals with moderate-to-severe brain injuries exhibit overall cognitive impairment. She performed neuropsychological evaluation which indicated that appellant's overall intellectual functioning resulted in a notable decline as compared to his estimated premorbid functioning. Dr. Basile noted that he had a lower threshold for cognitively taxing tasks, his verbal reasoning skills were relatively intact, and he experienced mild anomic aphasia. She also advised that appellant displayed deficits in auditory and visual attention span, he had significant decline in overall auditory and visual memory recall, deficits in safety awareness and judgement skills, and a high level of mood symptoms.

By decision dated April 6, 2017, OWCP denied modification of its January 15, 2016 decision regarding cervical spondylosis with myelopathy.

LEGAL PRECEDENT

An employee seeking benefits under FECA[5] has the burden of proof to establish the essential elements of his or her claim, including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was filed within the applicable time limitation of FECA, that an injury was sustained in the performance of duty as alleged, and that any disability or specific condition for which compensation is claimed is causally related to the employment injury. These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[6]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether fact of injury has been established. There are two components involved in establishing fact of injury. First, the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the

[5] *Supra* note 2.

[6] *Gary J. Watling*, 52 ECAB 357 (2001).

time, place, and in the manner alleged. Second, the employee must submit medical evidence to establish that the employment incident caused a personal injury.[7]

Rationalized medical opinion evidence is generally required to establish causal relationship. The opinion of the physician must be based on a complete factual and medical background, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[8]

ANALYSIS

Appellant alleged that he sustained an injury on November 16, 2015 when he tripped on a step and fell while carrying two bundles of mail. OWCP found that the incident occurred on November 16, 2015 as alleged and that it resulted in the accepted laceration above the right eye and forehead hematoma. However, it also found that appellant had not established that the employment incident caused cervical spondylosis with myelopathy causally related to the November 16, 2015 employment injury.

The Board finds that the medical evidence of record is insufficient to establish additional conditions causally related to the November 16, 2015 employment incident. Appellant submitted December 3, 2015 to February 10, 2016 reports from Dr. Kulick who noted originally treating appellant in 2011 for chronic neck pain with arm numbness. He noted that a 2011 cervical spine MRI scan showed spondylitic spurring and spinal cord compression with myelomalacia. Appellant presented on December 3, 2015 after falls in 2013 and 2015. He reported the November 16, 2015 work fall where appellant struck his right frontal region and sustained a right periorbital hematoma and a right scalp hematoma. Dr. Kulick diagnosed cervical spinal cord compression secondary to cervical spondylitic disease and indicated that appellant had several traumatic brain injuries due to falling secondary to cervical myelopathy. Although he supported causal relationship, he did not provide sufficient medical rationale explaining the basis of his conclusory opinion that appellant's additional conditions were due to the November 16, 2015 incident.[9] Dr. Kulick did not explain the process by which the November 16, 2015 fall would have caused or aggravated the diagnosed condition and why such condition would not have been due to any nonwork factors.[10] Medical rationale was particularly necessary given that appellant has a preexisting cervical spondylitic spurring and spinal cord compression as noted in the 2011 MRI scan. As the opinion of appellant's

[7] *T.H.*, 59 ECAB 388 (2008).

[8] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[9] *See T.M.*, Docket No. 08-0975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

[10] *Id.*

physician regarding causal relationship was not sufficiently explained, it was insufficient to meet appellant's burden of proof.[11]

In a September 8, 2016 report, Dr. Kulick noted appellant's history including his falls in 2013 and 2015, most recently on November 16, 2015, in which he struck his right frontal region and sustained a right periorbital hematoma. He diagnosed cervical spinal cord compression secondary to cervical spondylitic disease and several traumatic brain injuries due to falling. Dr. Kulick indicated that appellant's falling and weakness in his extremities and instability were related to moderate-to-severe cervical spinal cord compression secondary to cervical spondylosis. He opined that each of the falls produced traumatic brain injury in 2013 and 2015 which accentuated the neuropsychological abnormalities. Dr. Kulick advised that based on his examination and the abnormalities noted on diagnostic and neuropsychological testing that appellant was totally disabled and incapacitated for any work. As noted above, although Dr. Kulick supported causal relationship, he did not provide sufficient medical rationale explaining the basis of his conclusory opinion that appellant's cervical spondylosis with myelopathy were due to the November 16, 2015 accepted work injury.[12] Medical rationale was particularly necessary given that appellant has a preexisting cervical spondylitic spurring and spinal cord compression.[13]

Appellant also submitted a January 5, 2016 attending physician's report from Dr. Kulick which noted appellant's history and diagnosed cervical spondylosis with myelopathy and intracranial injury. Dr. Kulick checked a box marked "yes" indicating that appellant's condition was caused or aggravated by an employment activity, noting appellant fell due to poor lighting. The Board has held that when a physician's opinion on causal relationship which consists only of checking "yes" to a form question, without explanation or rationale, is of diminished probative value and is insufficient to establish a claim.[14]

Appellant submitted January 11 and September 29, 2016 reports from Dr. Shiau in which he reviewed appellant's history and noted findings. Dr. Shiau diagnosed spinal stenosis, cervical region and unspecified disease of the spinal cord. On February 2, 2016 he performed a posterior C3-6 decompressive laminectomies with posterior fixation and fusion. On May 2, 2016 Dr. Shiau opined that appellant had a baseline cervical spondylosis that resulted in progressive myeloradiculopathy and gait imbalance. He further opined that appellant's most recent work-related fall in November 16, 2015 resulted in post-traumatic brain injury and accelerated his myelopathic dysfunction. Dr. Shiau noted that appellant was completely disabled. The Board finds that, although Dr. Shiau supported causal relationship, he did not provide medical rationale explaining the basis of his opinion that appellant's cervical spondylosis with myelopathy were due to the November 16, 2015 accepted work incident.[15] Dr. Shiau did not explain the process by

[11] *J.M.*, 58 ECAB 478 (2007) (the Board found that appellant had not met his burden of proof to establish a work-related right wrist condition where his physician provided only conclusory support for causal relationship; medical rationale was particularly necessary as appellant had a preexisting wrist injury).

[12] *See T.M.*, *supra* note 9.

[13] *See J.M., supra* note 11.

[14] *D.D.*, 57 ECAB 734 (2006); *Sedi L. Graham*, 57 ECAB 494 (2006).

[15] *See T.M.*, *supra* note 9.

which the November 16, 2015 fall would have caused or aggravated the diagnosed condition and why such condition would not have been due to any nonwork factors. As noted, the need for medical rationale is particularly important in view of appellant's preexisting cervical spondylosis.[16] Consequently, Dr. Shiau's opinion is insufficient to meet appellant's burden of proof.

In a December 12, 2016 report, Dr. Basile noted that appellant had two traumatic brain injuries in the past three years and had since exhibited symptoms of global decline. She noted that he had a lower threshold for cognitively taxing tasks, he experienced mild anomic aphasia, he displayed deficits in auditory and visual attention span, he had significant decline in overall auditory and visual memory recall, and deficits in safety awareness and judgement skills. However, Dr. Basile's opinion is of limited probative values as she did not provide a rationalized opinion explaining how or why the November 16, 2015 work injury caused or contributed to a diagnosed condition.[17]

Appellant submitted emergency room notes from Dr. Ilyayev dated November 16, 2015 who treated him for a head injury. Dr. Ilyayev reported that appellant accidentally tripped and fell at work, hitting his forehead on the concrete. He noted findings of superficial abrasion and hematoma to the right periorbital area. Dr. Ilyayev diagnosed closed head injury without concussion. These notes are insufficient to establish appellant's claim as Dr. Ilyayev did not address whether the November 16, 2015 employment-related fall had caused or aggravated the diagnosed cervical spondylosis with myelopathy.[18] Likewise, reports from other physicians are of limited probative value as they did not specifically address whether the November 16, 2015 employment-related fall had caused or aggravated the claimed condition.[19]

Also of record are physical therapy and physician assistant notes. The Board has held that document notes signed by a physician assistant or a physical therapist lack probative value as physician assistants and a physical therapists are not considered physicians under FECA.[20] These records are, therefore, insufficient to establish appellant's claim.

On appeal counsel asserts that OWCP erred in its April 6, 2017 merit decision. He argued that appellant submitted sufficient evidence to establish additional conditions related to the November 16, 2015 employment injury. As found above, the medical evidence of record does not establish additional medical conditions causally related to the November 16, 2015 employment

[16] *See J.M., supra* note 11.

[17] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

[18] *A.D.*, 58 ECAB 149 (2006); Docket No. 06-1183 (issued November 14, 2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

[19] *Id.*

[20] *See David P. Sawchuk*, 57 ECAB 316, 320, n.11 (2006) (lay individuals such as physician assistants, nurses and physical therapists are not competent to render a medical opinion under FECA); 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

injury. Appellant has not submitted a physician's opinion which sufficiently describes how the November 16, 2015 employment injury caused or aggravated additional conditions.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish cervical spondylosis with myelopathy causally related to the accepted November 16, 2015 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the April 6, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 3, 2018
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board